1886(d)(5)(L) of the Act, which authorize the Secretary to establish a mechanism to recognize the costs of new medical services and technologies under the hospital inpatient prospective payment system.

(b) *Eligibility criteria.* For discharges occurring on or after October 1, 2001, CMS provides for additional payments (as specified in §412.88) beyond the standard DRG payments and outlier payments to a hospital for discharges involving covered inpatient hospital services that are new medical services and technologies, if the following conditions are met:

(1) A new medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. CMS will determine whether a new medical service or technology meets this requirement and announce the results of its determinations in the FEDERAL REGISTER as a part of its annual updates and changes to the hospital inpatient prospective payment system.

(2) A medical service or technology may be considered new within 2 or 3 years after the point at which data begin to become available reflecting the ICD–9–CM code assigned to the new service or technology (depending on when a new code is assigned and data on the new service or technology become available for DRG recalibration). After CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical service or technology, the medical service or technology will no longer be considered ''new'' under the criterion of this section.

(3) The DRG prospective payment rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate, based on application of a threshold amount to estimated charges incurred with respect to such discharges. To determine whether the payment would be adequate, CMS will determine whether the charges of the cases involving a new medical service or technology will exceed a threshold amount set at 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant DRGs if the new medical service or technology occurs in many different DRGs). Standardized charges reflect the actual charges of a case adjusted by the prospective payment system payment factors applicable to an individual hospital, such as the wage index, the indirect medical education adjustment factor, and the disproportionate share adjustment factor.

[66 FR 46924, Sept. 7, 2001, as amended at 68 FR 45469, Aug. 1, 2003]

§ 412.88 Additional payment for new medical service or technology.

(a) For discharges involving new medical services or technologies that meet the criteria specified in §412.87, Medicare payment will be:

(1) One of the following:

(i) The full DRG payment (including adjustments for indirect medical education and disproportionate share but excluding outlier payments);

(ii) The payment determined under §412.4(f) for transfer cases;

(iii) The payment determined under §412.92(d) for sole community hospitals; or

(iv) The payment determined under §412.108(c) for Medicare-dependent hospitals; plus

(2) If the costs of the discharge (determined by applying cost-to-charge ratios as described in §412.84(h)) exceed the full DRG payment, an additional amount equal to the lesser of—

(i) 50 percent of the costs of the new medical service or technology; or

(ii) 50 percent of the amount by which the costs of the case exceed the standard DRG payment.

(b) Unless a discharge case qualifies for outlier payment under §412.84, Medicare will not pay any additional amount beyond the DRG payment plus 50 percent of the estimated costs of the new medical service or technology.

(c) If CMS estimates before the beginning of a Federal fiscal year that the additional payments under this section would exceed 1.0 percent of total operating payments under the hospital inpatient prospective payment system, the additional payment

amounts under paragraph (a) of this section will be reduced prospectively to a percentage estimated to result in payments not to exceed 1.0 percent of total operating payments under the hospital inpatient prospective payment system.

[66 FR 46924, Sept. 7, 2001, as amended at 67 FR 50111, Aug. 1, 2002]

Subpart G—Special Treatment of Certain Facilities Under the Prospective Payment System for Inpatient Operating Costs

§412.90 General rules.

(a) *Sole community hospitals.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hosptials, is the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries. If a hospital meets the criteria for such an exception under §412.92(a), its prospective payment rates for inpatient operating costs are determined under §412.92(d).

(b) *Referral center.* CMS may adjust the prospective payment rates for inpatient operating costs determined under subpart D or E of this part if a hospital acts as a referral center for patients transferred from other hospitals. Criteria for identifying such referral centers are set forth in §412.96.

(c) [Reserved]

(d) *Kidney acquisition costs incurred by hospitals approved as renal transplantation centers.* CMS pays for kidney acquisition costs incurred by renal transplanation centers on a reasonable cost basis. The criteria for this special payment provision are set forth in §412.100.

(e) *Hospitals located in areas that are reclassified from urban to rural.* (1) CMS adjusts the rural Federal payment amounts for inpatient operating costs for hospitals located in geographic areas that are reclassified from urban to rural as defined in §412.62(f). This adjustment is set forth in §412.102.

(2) CMS establishes a procedure by which certain individual hospitals located in urban areas may apply for reclassification as rural. The criteria for reclassification are set forth in §412.103.

(f) *Hospitals that have a high percentage of ESRD beneficiary discharges.* CMS makes an additional payment to a hospital if ten percent or more of its total Medicare discharges in a cost reporting period beginning on or after October 1, 1984 are ESRD beneficiary discharges. In determining ESRD discharges, discharges in DRG Nos. 302, 316, and 317 are excluded. The criteria for this additional payment are set forth in §412.104.

(g) *Hosptials that incur indirect costs for graduate medical education programs.* CMS makes an additional payment for inpatient operating costs to a hospital for indirect medical education costs attributable to an approved graduate medical education program. The criteria for this additional payment are set forth in §412.105.

(h) *Hospitals that serve a disproportionate share of low-income patients.* For discharges occurring on or after May 1, 1986, CMS makes an additional payment for inpatient operating costs to hospitals that serve a disproportionate share of low-income patients. The criteria for this additional payment are set forth in §412.106.

(i) *Hospitals that receive an additional update for FYs 1998 and 1999.* For FYs 1998 and 1999, CMS makes an upward adjustment to the standardized amounts for certain hospitals that do not receive indirect medical education or disproportionate share payments and are not Medicare- dependent, small rural hospitals. The criteria for identifying these hospitals are set forth in §412.107.

(j) *Medicare-dependent, small rural hospitals.* For cost reporting periods beginning on or after April 1, 1990 and before October 1, 1994, or beginning on or after October 1, 1997 and before October 1, 2006, CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part if a hospital is classified as a Medicare-dependent, small rural hospital.